Occupational Therapy Community Referral Form

Phone: xxxxxxxx or xxxxxxxx
Fax: xxxxxxxxx

PLEASE Answer all questions by inserting X in the appropriate box [ ] and supplying details where applicable. If the referral form is not complete your referral form may be returned and the referral declined.

DATE:		**MRN/PMI:**		
SURNAME:	**OTHER NAMES:**			**M/F:**
ADDRESS:		**DOB:**	**Aboriginal** **Yes** [ ] **No** [ ] **Torres Straight Islander** **Yes** [ ] **No** [ ]	
PHONE: Home	**Work:**	**Mobile:**	**GP:**	
REFERRER:	**POSITION/RELATIONSHIP:**	**Medicare/DVA No:**		
ORGANISATION:	**PHONE:**	**FAX:**		

Reason for referral:

Diagnosis:

CURRENT ABILITIES

Indoor Mobility

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]
No aids	[ ]	Walking Stick	[ ]	Frame	[ ]	Wheelchair	[ ]

Comments:

Outdoor Mobility

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]
No aids	[ ]	Walking Stick	[ ]	Frame	[ ]	Wheelchair	[ ]

Comments:

Bed transfers

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]

Comments:

Chair transfers

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]

Comments:

Toileting

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]

Comments:

Showering

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]

Dressing

Independent	[ ]	Needs a little help	[ ]	Needs a lot of help	[ ]	Not known	[ ]

Meal preparation

Independent [ ] Needs a little help [ ] Needs a lot of help [ ] Not known [ ]

Comments:

RECENT CHANGES

Have the clients abilities changed in the last month?	Yes	[ ]	No	[ ]	Not Known	[ ]
Have they been in hospital within the last 2 weeks?	Yes	[ ]	No	[ ]	Not Known	[ ]

FALLS HISTORY

Has the client fallen at home in the last 6 months? *Comments:*	Yes	[ ]	No	[ ]	Not Known	[ ]
Has the client had any falls in the surrounds or community in the last 3 months?	Yes	[ ]	No	[ ]	Not Known	[ ]

PRESSURE CARE

What is the client's Waterlow score?	20+	[ ]	15+	[ ]	10+	[ ]
Does the client have an existing pressure area?	Yes	[ ]	No	[ ]	Not Known	[ ]
What Grade is the wound?	1	[ ]	2	[ ]	3+	[ ]
Where is the wound located? *Comments:*						
Does the client already have pressure relieving equipment? *Comments (mattress/cushion/other plus brand/model if known)*	Yes	[ ]	No	[ ]	Not Known	[ ]

LIVING SITUATION

Does the client live alone? Comments:	Yes	[ ]	No	[ ]	Not Known	[ ]
Does the client have a carer? *Comments (please indicate any reported carer stress):*	Yes	[ ]	No	[ ]	Not Known	[ ]
Is the client a carer for someone else? *Comments:*	Yes	[ ]	No	[ ]	Not Known	[ ]

CURRENT SERVICE INVOLVEMENT

Community Services (e.g. Homecare, MOWs) In-home respite referral was made by discharge planner.	Yes	[ ]	No	[ ]	Not Known	[ ]
Community Nurses For pressure wound dressing	Yes	[ ]	No	[ ]	Not Known	[ ]
ACAT	Yes	[ ]	No	[ ]	Not Known	[ ]
EACH/EACH(D)	Yes	[ ]	No	[ ]	Not Known	[ ]
Palliative Care	Yes	[ ]	No	[ ]	Not Known	[ ]
DVA eligible	Yes	[ ]	No	[ ]	Not Known	[ ]

CONTACT FOR APPOINTMENT

Is there any reason that we should contact someone other than the client to arrange an appointment?	Yes	[ ]	No	[ ]	Not Known	[ ]

Reason: *(e.g. memory problems, difficulty hearing, NESB, difficulty making decisions*

Name of contact person:

Relationship to client: